AutoShip Authorization Form

Patient Name_____

Shipping Address_____ Apt #_____

City_____ State_____ Zip_____

Phone_____ Fax_____ Email_____

PRODUCT DESCRIPTION	PRICE	QTY.	

AUTOSHIP DAY OF THE MONTH _____

All AutoShip orders falling on a weekend or holiday will ship out the next business day.

AUTOSHIP EVERY _____ MONTH(S)

Subtotal	
S & H	
Tax	
TOTAL	

PAYMENT INFORMATION

Method of Payment: ☐ VISA ☐ Master Card

CC#_____ Exp. _____

Name on card _____ Signature _____

Billing Address_____ Apt _____
(if different from above shipping address)

City_____ State_____ Zip_____

AGREEMENT

TERMS AND CONDITIONS

As a participant in the AutoShip program I authorize _____ to automatically ship my order detailed above periodically as described above after processing the payment method that I have indicated. _____ is under no obligation to ship any products until full payment has been received. Shipment will take place approximately two days from payment confirmation. This agreement will remain in effect until I cancel in writing.

REVISION

I may revise my AutoShip Agreement during any month. To do so, I must submit a new AutoShip Agreement and write "Modify AutoShip" at the top of this form. _____ must have revisions no later than 5 calendar days prior to my next AutoShip shipment date. If the revision is received less than 5 calendar days prior to shipment, there will be no guarantee that the revision will be effective for that shipment.

CANCELLATION

If I decide to cancel my AutoShip Agreement, I must contact _____ no later than 2 calendar days prior to my next AutoShip shipment date. If the cancellation is received less than 2 calendar days prior to shipment, there will be no guarantee that the order will not ship.

PATIENT SIGNATURE_____ DATE_____